Health Care Cost Trends Hearing

6-28-11 AM

Seena Perumal Carrington

Good morning. Thank you all for joining us, and I welcome you to the second day of the Division's public hearings on health care cost trends. I'm Seena Perumal Carrington, Acting Commissioner of the Division of Health Care Finance and Policy, and Chair of these hearings. I'm joined today by Karen Tseng, Assistant Attorney General.

So let me begin by acknowledging the obvious. Massachusetts enjoys a robust healthcare delivery system. The Commonwealth Fund ranks Massachusetts seventh overall among states, on its state score card which measures health system performance. This success can be partly attributed to a strong provider network, which includes some of the highest ranked hospitals on quality indicators, and health insurers that are consistently rated among the top ten best plans in each category nationwide. But at the same time, the Commonwealth is grappling with escalating health care costs, which are consuming a greater portion of the economy. Yesterday, we heard from experts about rising health care costs in the state, specifically health care spending per member grew 5 percent from 2007 to 2008, while per capita GDP only grew by 2 percent during that same time period.

Price, not utilization, is the single most important factor fueling rising private health care spending, while it is just the opposite for public payers, in which greater service use led to increased spending. Therefore today, we will examine price variation in health services. We will start with a presentation of analytical findings, from both the Division of Health Care Finance and Policy, and the Office of the Attorney General. I must admit, during my entire time at the Division, I don't think we've ever released a report that's garnered such criticism or such praise, except perhaps our review of the reserves and surpluses of hospitals and insurers.

After our presentations of analytical findings, we're going to have a panel discussion of providers and payers discussing the factors that may underlie price variation, and potential strategies to address the extent of the variation. The panel will be moderated by Michael Bailit, who also serves as the lead consultant to the special commission on provider price reform, which was created by Chapter 288 of the Acts of 2010. For those of you who may be less familiar with that group, the special commission will meet many times over the summer to produce a report with recommendations for reducing the disparities in reimbursement rates.

We will then break for a 45-minute lunch. The café is located on the first floor and there are many restaurants nearby. We're going to begin promptly again at 12:45 p.m., with a presentation by Dr. Michael Chernew, Professor of Health Care Policy at Harvard Medical School, regarding the consumer's role in cost containment. Lastly, we will have a panel of witnesses moderated by Dr. Chernew, who will discuss price and quality transparency and how that can inform more prudent health care purchasing decisions and impact utilization patterns. Panelists will be sworn in, and will therefore be providing their testimony under oath. While the moderator will ask the majority of questions, Karen or I may intervene at any point if we wish to dig further into an issue. I would like to encourage all of you in attendance to engage with the information and ideas being shared. There's index cards available in your folder. Please write any questions that you may have for panelists or the expert witnesses, and give them to members of my team, who will be walking around. At the end of each panel, the moderator will ask some of the submitted questions and ultimately, based on the information presented today, the Division is charged with developing a final report with recommendations.

Before we proceed, I want to emphasize a point of critical importance. If we're ever to make progress on cost containment, we need to have frank, open discussions. If you don't agree with our findings tell us, but also tell us how to make it better and then provide us with the underlying data so that we can analyze it. Otherwise, as the Governor noted yesterday, we're always going to get lost debating numbers, when this conversation should really be about providing relief to Massachusetts residents from escalating, unsustainable health care costs. And so with that, let me begin by introducing Stacey Eccleston, Assistant Commissioner for Health Research and Policy at the Division.

Stacey Eccleston

Thank you. As Commissioner Carrington said, yesterday we looked at the growing expenditures and saw that price was an important driver of those expenditures. This analysis today that we'll be looking at, digs deeper into those prices. It uses the same data that was used for the expenditure analysis. In particular, the study uses 2009 data, so it looks at the prices that were paid for services that were delivered in 2009. We look at the private payer prices and we look at commercially insured members in a variety of setting. We look at inpatient hospital, outpatient hospital, as well as physician and other professional services. The prices paid by the commercial carriers are then compared to both Medicaid and Medicare. We look at the variation in quality scores that are specific to the particular DRGs that we're looking at, and how those relate to -- and how the variation of the quality scores relate to the price variation. And finally, we look at some potential cost savings that would be associated with either reducing or eliminating that variation.

The report itself, if you've seen it, includes the main report, as well as a statistical appendix and a technical appendix that explains the methodology. The statistical appendix contains sort of detailed information for multiple services in DRGs. So what we're able to do in a presentation today is just provide some examples of those, but you can be assured that if you go to the report itself, you can see the detail for all of those.

So what I want to first start out, is give you an overview and then demonstrate each one of these findings using some examples. There were several findings. First; there was substantial price variation that we found across all providers and all service types. The highest paid hospitals, for example, received average payments that were anywhere between 50 percent to 100 percent higher than the lowest paid hospitals, for the same services. Tertiary care hospitals, those that perform cardiac and neurosurgery, tended to have higher prices compared to community hospitals, for again the same services, but this wasn't always the case. Sometimes, geographically isolated community hospitals also had higher prices.

For the professional services, they were up to a six-fold differences in actual CPT prices that were paid. We also found that the volume of discharges in a hospital tended to occur in the higher paid hospitals, for each of the DRGs. And again, we'll look at an example of that. We found little variation among hospitals based on the quality metrics that were specific to the 14 DRGs that we're taking a look at, yet the price variation for those same 14 DRGs was quite wide. In addition, I mentioned we did some savings simulations that showed, among other scenarios, what narrowing the price variation to the existing 20th and 80th percentile would yield in terms of savings, and found about $267 million in savings on just the inpatient and the professional services side. Other scenarios that we tested would yield even greater savings.

In comparison to public payers, we found that Medicare and in particular Medicaid rates, were consistently lower than the prices that are paid by the private payers, with a couple of notable exceptions to that. We also found that the hospitals with the highest proportion of Medicaid patients are not those that have the highest private pay prices, and we looked at this because we heard that the need to compensate for lower Medicaid prices was a driver of the variation in that prices, so we wanted to explore that. So it's not to say that the cost shifting doesn't occur, but rather it doesn't appear to explain the variation in the prices that we look at. Otherwise, those with the greatest need for the cost shifting, those with the greatest proportion of Medicaid patients, would then be those with the highest private payer prices, so it may have to do more with the ability to negotiate those prices. And finally, while we find that the variation in Medicare prices was similar in breadth to that that we found for the private payer prices, so the highest paid hospitals in Medicare were nearly double the lowest paid hospitals. The rankings of the hospitals are quite different between the two.

So let's give a brief example of each of these points, and before I do that, I just want to give you a little bit of a methodological overview. The data that we used came from claims submissions from five large payers, both fully and self-insured claims, and these accounted for about 80 percent of the privately insured market in the state. So it's pretty representative. The prices paid are for services that were rendered in 2009, and they include the carrier's payments, as well as any of the co-payments that were paid by the patients themselves. The inpatient prices are calculated both on a statewide basis, as well as a hospital specific level. The professional prices were only available at the statewide level. All of the hospital specific analysis, so whenever you're seeing any of the hospital comparisons, the prices are severity adjusted median prices. So that means that we're sort of holding the severity across the hospitals constant, so case mix isn't driving those differences. And we're only including hospitals where there are at least 30 discharges for the given DRG, and enough within each severity level to make those adjustments.

We looked specifically at 14 DRGs that made up about 40 percent of the total inpatient payments on average. Those DRGs were chosen as ones that were frequently occurring across all hospital types. Also, we wanted to make sure that we had ones where there were quality measures available. For the professional services, we used 20 CPT codes; those made up about 32 percent of the professional payments, and here we chose the most important CPT codes within different categories of services, so within the office visit category, within the surgical category, radiology, physical medicine.

The quality measures that we're looking at are composites that were specifically tailored to each of the DRGs, and the comparisons of the private payer prices to Medicaid and Medicare, basically used the fee schedule rates for that comparison. The Medicaid Standard Payment Amount per Discharge, or SPAD, had to be converted to DRG-specific rates, because as you know, Medicaid pays one single rate to all of the hospitals. So we were able to convert that single rate into DRG-specific rates.

For our first finding, we said that the price variation for inpatient hospitals services was wide, and that the highest paid hospitals receive payments that are anywhere between 50 to 100 percent higher than the lowest paid hospitals. Here we're showing the severity adjustment price relativities, where the median hospital here is equal to one, for the 14 DRGs. So we take the severity adjusted median price paid to each hospital and just simply divide that by the median paid across all of the hospitals, to create what's like an index here, or what we're referring to as the price relativity. So for pneumonia here, the lowest paid hospital received payments there were about 75 percent of the median hospital, and the highest hospital here received payments that were about 26 percent higher than the median hospital.

The range was narrower for DRGs, such as hip joint replacement and congestive heart failure, and most significant about double from the low to high for cesareans, AMI and appendectomies. In the report and in the appendix, you can for each of these DRGs, the relative positioning of each hospital that we looked at. Here we'll demonstrate using the services here that are in green, so a medical stay, pneumonia, a surgical stay, knee joint replacement, and the two childbirth stays, since these are by far the most frequent DRGs that occur across the state, and so they make up the largest proportion of the dollars.

So each one of those four DRGs, we'll start with pneumonia, we see that the highest paid hospital in this case -- and in this case Mass General, received about $9,000 per discharge, while the lowest paid hospital, Brockton Hospital, received about $5,500 per discharge. The range here is about 1.7 times from the low to high, and remember, these are severity adjusted prices that are paid. Here we're talking about the facility payments for those DRGs, so it doesn't include the surgeon's charge, the physician's charge or the obstetrician's charge in the case of the deliveries.

For the knee joint replacement, our surgical stay, the spread is about 1.8 times from low to high; Lowell General at about $14,000, compared to Brigham and Women's at about $25,000. For cesarean delivery, the highest paid hospital receives more than double what the lowest paid hospital receives, about $10,500 compared to about $5,000 for the lowest paid hospital. And here the range is more than double, from low to high. And we see a similar spread for vaginal delivery; $3,400, compared to about $6,000 for the highest paid hospital. And if you were to look at all of the other DRGs, you see a pretty similar picture.

Here we also noted earlier, that there tended to be higher prices paid to tertiary care hospitals, compared to the community hospitals, and you can see that many of those tertiary care hospitals here, colored in green, are found at the right side of the chart, the higher end, but that's not true in all cases. For example, South Shore Hospital, not a tertiary care hospital, has relatively higher prices for this DRG while St. Vincent's or Boston Medical Center for example, had relatively lower prices for this service.

We also said that more of the volume of discharges happens to occur at the hospitals that are at the higher end of the price scale, and this is true for all of the DRGs. Taking a look at our four example DRGs, again here we see the pneumonia, we see that about 60 percent of the discharges occur at the upper end of the range, with 35 percent of the discharges occurring in that third quartile of prices that range from about $7,300 to about $8,100. This chart here just simply shows you the percent of discharges for the DRG, in this case pneumonia, that occur at the hospitals, in each of four different quartile levels. More typically, actually what we see for all of the rest of the DRGs, looks more similar to this chart, where the majority of the discharges actually occur at the very highest or top quartile. Here, for the knee joint replacement, nearly one half of the discharges were at hospitals in the top quartile of the prices, that range from about $22,000 to about $25,000. Same thing for cesarean delivery; here about 45 percent of the discharges occurred at the very top quartile of prices. In fact for cesarean delivery, about 70 percent of all of the discharges occur at the hospitals that are in the upper half of that price range. And again, for the vaginal delivery, a similar story, with only about 12 percent of all discharges occurring at hospitals that were at that lower priced quartile. And again, the report itself presents this information for each of the

DRGs, where we have enough volume to look at the hospitals, and the picture looks pretty similar to what you see here.

Well what about quality? We created an index, or a relativity, very similar to what we did for the price relativity, for the quality relativity. That is, each of the hospitals' composite score was divided by the statewide average to create that index. So for pneumonia, the lowest hospital was just three points below the median and the highest was just three points above, so a spread in quality of just six points. Remember for the price relativity that we saw, it was a much greater spread, more than 50 points here. So for each DRG here, you can see a very narrow range in the scores, typically with a spread of just about eight points, from low to high, the most significant spread being for COPD, 92 to 1.13, and the vaginal delivery, 94 to 1.06. So basically there was very little variation in the composite quality scores for these DRGs.

Just a word about how we get those scores. The quality measures were selected to be specific to each DRG. So generally, they consist of three different domains; patient experience, which is hard set to account for 25 percent of the score, and then the process of care and outcome measures from CMS, which make up the other 75 percent. So if we take pneumonia for our example here, the CMI process measures specific to pneumonia, account for 25 percent, and those include the things that are listed here. Readmission rates, specifically for pneumonia, account for 25 percent of that composite score. Mortality rates again, specific to pneumonia, account for another 25 percent of that score, and then the patient experience measures account for 25 percent of the score. Surgical process outcome measures were applied to all the surgical condition. Patient safety indicators were applied to the births, and all of this is detailed in the report itself.

So we said that we compare the quality relativities to the price relativities. This is a depiction of that and again, we'll look at our four sample DRGs. Here we're looking at pneumonia, and the quality relativity is the blue bars here, and you can see there's very little difference in the quality relativities, ranging from just below one to just above one, so just a slight slope in those bars. On the other hand, the price relativities are quite varied and there's a much wider range. In addition, the hospitals at the lower end of the quality scale here, to the left, have prices that are relatively higher sometimes, and while the hospitals with the highest quality ranking, Mount Auburn in this case, has one of the lowest price relativities, under .9. Although keep in mind here that when we're looking at these quality scores, there is very little different and they're all quite high; all the hospitals are relatively high for these quality measures.

When we look at knee joint replacement, our other DRGs, we see a similar thing; little variation in the quality and much variation in the price. And the hospital at the lowest end of the quality relativity has one of the higher prices, at 1.2, and some of the hospitals at the upper end on quality, like Winchester, had relatively lower prices, at .9.

For cesarean delivery, a similar wide variation in prices and a narrow variation in quality, with again some of the highest prices hospitals being at the lower or the middle of the quality metric here, and a hospital like Milford Regional, at the highest end of the quality scale, having prices that were among the lowest, at .89. And finally for the vaginal delivery, the same story once again, with the hospital at the lowest end of the quality scale having among the highest prices, and a hospital like Tufts Medical Center, at the upper end of the quality scale, having prices that are pretty typical. And with the report and the appendices again, you see a similar thing for the rest of the 14 DRGs.

Well, what about if there wasn't such variation in the prices, what would that mean? We did some simulations where we determined what the potential savings would be if we narrowed that variation. We chose four different scenarios; one where we assume all payments to be made at the median, and this is across all the DRGs. So across the DRGs, a move to all payments at the median, so increasing those below the median, up to the median, decrease those above the median to the median, and that would result in about a 3.3 percent savings.

Another scenario that we looked at. Looked at reducing the payments that were above the 80th percentile, down to the 80th percentile, and that scenario resulted in savings of about 5 percent overall. Another scenario looked at reducing the payments above the 80th percentile, down to the 80th percentile, while at the same time increasing those below the 20th percentile, up to the 20th percentile, so a squeeze in both directions if you will. And here we still result in savings, even though we're increasing some of the prices and even though it's a symmetrical narrowing, and you save more dollars by reducing at the upper end than you add on by increasing at the lower end. And we also modeled what the increase in payments would be if we only increased those below the 20th, and that would result in about a 2.4 percent increase.

All of the simulations were done specifically at the DRG and the severity level, and then those were summed up. So the variation that we see in the distribution that we start with, isn't due to different severity levels, so we're doing it within severity and then summing up those total savings or increases.

We did a similar thing for the professional services, or the CPT codes, with the identical scenarios that we just saw, and we found a potential 10 percent in savings for having all of the payments made at the median, a 5 percent decrease in payments for those -- reducing those about the 80th to the 80th percentile, and a 2.8 percent decrease in payments for increasing the bottom 20th percentile while at the same time decreasing those above the 80th percentile of payments. The greatest percentage savings for professional services can be found for therapeutic exercises here, though this is a relatively low cost procedure and moderate complexity office consultations and radiological exams.

We also compared the private payer prices to the Medicaid prices, and here's just a table with an example of four DRGs. The table shows the DRG individually for each of the severity levels that we have. We didn't put the fourth one on here, just to save room, but there's four severity levels, and it shows the median private payer price, the Medicaid price as derived from that SPAD that we talked about, the private payer median price as a percent of Medicaid. So for pneumonia here, for severity level one, the private payer price is about 165 percent of the Medicaid price, so 65 percent higher. And the last two columns here show you the distribution among the different severity levels, basically showing that they look pretty similar between both the Medicaid and the private payer prices. About 20 percent of pneumonia discharges, for example, were for severity level one for both Medicaid and for the private payers.

Looking down the column of the private payer price as a percent of the Medicaid price, you can see that in all cases, except for severity level three on the bottom one, for vaginal delivery, the Medicaid prices were quite a bit lower than what we see for the private payer prices, particularly for AMI. The closest range was for the deliveries. In fact, some hospitals receive higher payments from Medicaid than they do from private payers, for deliveries. This table lists just the bottom ten hospitals and the top ten hospitals, in terms of their private payer price, so a lot of hospitals in the middle here are not shown. We can only fit so many hospitals, so it's just the hospitals that are in the middle are not shown. But what you can see here is that for those bottom ten hospitals, the Medicaid price is actually higher than the private payer price, whereas for hospitals like Cooley Dickinson and Fairview, that are in the top ten hospitals on the private payer side, had much lower Medicaid prices. The private payer prices were about 45 percent higher. Another thing you can easily note on this slide is the narrow range generally, that we see for Medicaid prices. That just reflects modest adjustments for a variety of things, like geography.

Private payer prices were also higher for physician's services. Here we can look at both Medicaid and Medicare, and while Medicare prices were about 72 percent higher for an MRI, it is Medicare prices that are higher for psychotherapy and physical medicine procedures. This is likely due to the fact that there is no distinction made in Medicare for a physician versus a physical therapist providing that service. Alternatively, all of the private payer prices were higher than Medicaid prices, but relatively close for the psychotherapy service, just 12 percent higher in this case.

We also noted that there didn't appear to be a correlation between the private payer price differentials and the differentials in the proportion of patients at a given hospital that were Medicaid patients. So here we're looking at appendectomy, and we've listed the hospitals again, with the lowest private payer prices at the top and those with the highest prices at the bottom, with many in the middle, again not shown here. And as you can see, the three hospitals with the lowest private payer prices, so Lowell, Lawrence and Bay State, have some of the highest proportion of Medicaid patients for this specific DRG and overall. So ranging from 20 to 34 percent of their patients are Medicaid. While the four hospitals with the highest prices; Children's, Sturdy, Brigham and Women's and Mass General, had some of the lowest proportion of Medicaid patients, between 6 and 10 percent for this specific DRG and up to 165 percent across all DRGs. A correlation that was run, shows that there was virtually no statistical correlation between the private payer price ranking and the proportion of Medicaid discharges.

Just another example of this, a similar picture is shown for vaginal delivery, with the lowest price hospitals on the private payer side, Holyoke and Cambridge Health Alliance, having more than two-thirds of their discharges for this particular service being Medicaid patients, while the highest priced hospitals at the bottom of this chart have less than a quarter. And again, no statistical correlation, and the picture here looks the same for all of the DRGs, and you can see that again, in the statistical appendix. So again, not to say that cost shifting doesn't occur, but it just appear to explain the variation in the prices, since those with the greatest cost shifting needs are not those that are able to negotiate the highest private payer prices.

Our last finding relates to Medicare. Medicare rate differentials reflect very specific factors. Here we used our health safety net data to get the Medicare rates, since they're based on Medicare payments. After we controlled for DRGs, what remains then are rate differentials that reflect differences in three things very explicitly; geographic factors, such as wage differences and cost of living, indirect medical education expenses and disproportionate share status. And I think it's that latter one that probably has the greatest influence on the Medicare price relativities.

So as a result of those three factors that are explicitly built into the Medicare rates, we see a variation in Medicare prices that are paid to hospitals that's quite similar, in breadth anyway, to what we saw for the private payers. Here we're showing again, the bottom ten hospitals, but this time for Medicare payments, and the top ten hospitals based on Medicare payments and how they rank. The first column shows that the lowest paid hospital by Medicare, which is Cooley Dickinson, had prices that are about 86 percent of the median, while the highest paid hospital by Medicare was paid about 64 percent above the median Medicare price, for a ratio of about 1.9 from low to high, and this is quite similar to what we see on the private payer side, with a ratio of 1.8. So while Cooley Dickinson is ranked number one in terms of the lowest paid by Medicare, it's ranked 39th for the private payer prices. North Adam is second lowest and 27th on the private payer scale. Alternatively, Tufts Medical Center and Boston Medical Center are ranked 43rd and 44th, so the two highest for Medicare in this group, while they ranked 25th and 14th respectively, on the private payer price side.

As I mentioned before, there's a lot of information in here. You can find the detail on all of those DRGs, on the methodologies, if you go to this website. Thank you.

Seena Perumal Carrington

Thank you Stacey. We'll now move to Karen Tseng from the Attorney General's office, to review their findings, before we begin with questions and answers.

Karen Tseng

Good morning. I'm Karen Tseng, Assistant Attorney General in the Health Care Division of Attorney General Martha Coakley's Office. With me today is Jennifer Smagula, Actuary with Gorman Actuarial, whom our office engaged for expert assistance in our examination of health care cost trends and cost drivers. I'm here this morning to share with you, our office's findings on the wide disparities in prices in the health care market, which are not tied to value. These increases in prices are the main reason our health care costs are rising. After I review our findings, Ms. Smagula will provide further details regarding how we approached our analysis, and then I will conclude with some recommendations for addressing price disparities and market dysfunction. To echo the Attorney General's remarks yesterday, we thank the many providers and payers who provided information during our examination, for their courtesy and cooperation. We look forward to an informed discussion on the pressing matter of price disparities and rising health care costs during these hearings.

How did our office evaluate health care costs? Like last year, we looked at two measures. Price is the negotiated amount that the insurance company pays a provider for delivering medical services. Price is important, because it tells us the amount that one provider gets paid, compared to another, for providing the same service. For example, when you have a choice between two high quality hospitals, price tells you how much more it costs the health care system if you choose to go to the higher priced hospital. Total medical expenses is an elegant measure that captures the total cost of caring for a patient. It takes all the prices for all of the services that a patient consumer and adds them up. In this way, total medical expenses reflects both price and volume. It shows us the total cost of caring for a patient over a period of time, usually shown per patient, per month. Total medical expenses can be health status adjusted to control for differences in health and demographics between two patient populations. This way, we can compare the total cost of care for equivalent populations. If it costs much more to care for one population than another, with no difference in quality results, that raises important questions of where and how we can begin to save costs.

Here are two tables showing the variation in hospital prices and the variation in physician prices, in three major insurers networks. Blue Cross Blue Shield, Harvard Pilgrim Health Care and Tufts Health Plan are the three largest commercial insurers in Massachusetts. Together, they make up more than two-thirds of the commercial insurance market. A 100 percent difference in price means one provider is being paid twice as much as another. A 200 percent difference in price means one provider is being paid three times as much as another, and so on. From these tables, we can see there is wide variation in hospital prices, with the highest paid hospital in each insurer's network being paid two and a half to four and a half times as much as the lowest paid hospital. For physicians, the story is the same.

Another way providers are paid are through global payments. There are also wide disparities in global payments. Health insurers and providers negotiate a target amount, or global budget, that will be paid to the provider for all of the care the provider's patients receive over the year. We health status adjusted those global payments, so we control for differences in the demographics and health of the different populations cared for by the different providers. After controlling for these differences, some providers are still paid more than $400 per member per month, while others are paid less than $300 per member per month, to care for patients of comparable health and age. These wide differences in payment, whether fee for service or global payments, means higher paid providers have more to spend on many things; on building new facilities, on expanding operations into new communities, on technology for patient care, on recruiting, on salaries, on advertising and amenities. Our examination over the last two years focused on whether consumers and employers are getting value for those higher payments.

First, we looked at whether high prices are explained by better quality. To examine quality performance, we reviewed the best publicly available, well vetted and widely accepted data, focusing on outcome measures where available. Last year, we looked at how insurers evaluate provider quality, to determine whether quality was an important factor in the negotiation of provider prices. We found insurers' own assessment of quality performance did not correspond to the prices insurers paid providers. This year, we again examined whether there's a relationship between payment level and quality performance. We focused not on insurers' own assessment of quality, but on the best publicly available and widely accepted metrics. First, we sought to understand how Massachusetts providers compared to one another, and to their national peers on quality, and second, we sought to understand if wide disparities in prices can be adequately explained by quality differences. Again, we found they could not. Instead of tracking the wide disparities in price, we found that the quality performance of Massachusetts providers is similar and consistently high. Where national comparison data is available, Massachusetts providers usually score better than their national counterparts, and no providers are consistently among the best or the worst performers across categories.

For example, this next slide shows hospital performance across four clinical measures. We blinded the names of the hospitals in this slide because the goal is not to highlight or single out performers who performed less well, but to show the overall consistency in high quality performance. In general, Massachusetts hospitals perform within a tight range of each other and 52 of the 61 Massachusetts hospitals, or 85 percent of hospitals in Massachusetts, exceed national average performance. We saw similar results when we examined other measures of hospital and physician quality.

It has also been suggested that certain providers need to be paid two to three times their peers, because they have higher costs. We found that testimony filed for these cost trend hearings raised the important question of whether underlying costs drive the need for higher prices or whether higher prices allow for greater spending on salaries, amenities, capital construction, advertising and other costs. The Medicare Payment Advisory Commission has found that unusually high hospital margins on commercial patients can lead to more construction, higher hospital costs and lower government margins. MedPAC's data suggests that when commercial margins are high, hospitals face less pressure to constrain costs and so costs rise and government margins tend to be low.

This next slide examines government and commercial margins at similar hospitals in the Commonwealth. Here are the 2008 hospital margins, as reported under oath by three major Boston teaching hospitals. All three hospitals are major academic medical centers, offering extensive research and teaching programs, extensive resources for tertiary and quaternary care, and they are the principal teaching hospitals for their respective medical schools. Because of their similarity, these three hospitals are paid comparably by Medicare and Medicaid. The margin of these three similarly situation Boston hospitals, on their comparable government payments, ranges from -3 percent to -33 percent. On the commercial side, these three hospitals have negotiated payment levels that also result in very different margins, from 3 percent to 21.4 percent.

As many others have noted during these hearings, health care costs continue to grow faster than inflation, wages, and many other economic indicators. The Division of Health Care Finance and Policy, as you heard from Stacey just now, has found that increases in price are largely responsible for rapid growth in commercial health care costs. We found the same. Increases in prices which are not tied to value, are the main reason our health care costs are growing. In this slide, you can see that for each year since 2005, more than half of the increase in commercial health care costs, is due to increases in price; versus about 25 percent from increases in the number of services consumed.

Our health care costs are growing not only because of pure increases in price, but also because volume is increasingly concentrated at the higher paid providers. The Division of Health Care Finance and Policy found that inpatient service volume tends to be concentrated in higher paid hospitals. Similarly, last year, our office found that between 2005 and

2008, inpatient volume grew for higher pay providers while it shrank for lower paid providers. We also know, from this previous slide, that up to and including last year, the trend in provider mix, which is partially shown in the red bar, the trend in going to higher priced providers provider mix, continues to add to our health care costs.

The silver lining here is that we as a Commonwealth, have a significant opportunity to save costs, by shifting care to more efficient, high value providers. This is what the group insurance commission accomplished in reenrolling over 99 percent of state employees in health plans, with more than 30 percent of state employees choosing limited network plans that consist of high quality, lower cost providers. As you heard from Secretary Gonzalez yesterday, that shift in care, to lower cost high quality providers, is expected to save the Commonwealth $20 million next year. These findings highlight the importance of giving consumers and employers the tools and incentives to seek out high value, efficient providers, and to give those efficient providers a viable business model to compete on value.

Price disparities also contribute to differences in total medical spending. Recall that total medical spending is the sum of all of the cost of care for a patient over a given month.

This metric can be health status adjusted to control for factors like age and health status, so we are comparing the level of medical spending for comparable patients. For patients with higher health status adjusted TME, the additional amount being spent on their care is not explained by age or health. Instead, three factors explain differences in health status adjusted total medical spending. The patient with higher TME may be getting more health care services or utilization. Two, the patient may be using higher priced providers more often than the patient with lower TME, and three, the patient may be using more expensive treatments, known as service mix.

Our office examined whether there are differences in health status adjusted total medical spending across Massachusetts and we found there are. These results are shown in this slide. We received health status adjusted total medical expenses by zip code, from each of the three major health care insurers. We matched that total medical expenses information by zip code, with information from the Internal Revenue Service, on average income per zip code. In comparing the average TME per zip code with average income per zip code, we found that differences in total medical spending correlate with differences in income. The left most bar in this graph shows the 135 Massachusetts zip codes with the lowest health status adjusted total medical spending. More than half of these zip codes are also the zip codes with the lowest average incomes. To the far right of this graph, we see a bar that shows the zip codes with the highest total medical spending. Almost 60 percent of these high TME zip codes, are also the zip codes with the highest levels of income. If the increased cost of caring for patient with high TME is spread throughout a larger risk pool, as may happen in the small group market or in a single large employer group, those with lower TME may be subsidizing the higher cost of care of those with higher TME in the same risk pool.

Our office was able to conduct this analysis because of increased transparency in Massachusetts on important cost metrics, like total medical expenses. We hope this type of data and analysis will guide policymakers as they grapple with how to address dysfunction in our health care market. Because this is the first time this kind of analysis has been done in Massachusetts, I'd like to introduce you to Jennifer Smagula, our Actuarial expert, so you can hear directly from the expert who conducted this analysis.

Jennifer Smagula

My name is Jennifer Smagula. I am a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. Since July of 2010, I have been an actuarial subcontractor of Gorman Actuarial, where I have focused on assisting state governments in analyzing the impact of health care reform policies on the insured market. In addition, I have been responsible for pricing and trend analysis at two health insurance companies in Massachusetts; Blue Cross Blue Shield and Harvard Pilgrim Health Care. You heard yesterday from my colleague, Bela Gorman, regarding the key measures the AGO reviewed to understand costs in the health care market. I will focus my remarks today on the AGO's approach in analyzing the relationship between total medical expenses and income.

The AGO compared information on a health status adjusted total medical expenses, or TME, for each Massachusetts zip code, with income information for each zip code, to determine whether there is a relationship between health status adjusted TME and income. The TME data came from the three largest commercial insurers in Massachusetts. Blue Cross Blue Shield, Harvard Pilgrim, and Tufts Health Plan provided their 2009 member months and associated TME for each Massachusetts zip code. This data was separated by members, required to choose a PCP and those not required to choose a PCP. For each insurer, we combined the TME for these two groups, to maximize the number of members per zip code and therefore increase the credibility of the analysis. Where the insurers combined member months for a particular zip code was less than one thousand, we excluded that zip code from our analysis. In my opinion, excluding zip codes with fewer than a thousand member months increased the credibility of our results.

The TME from each insurer reflects allowed amounts, meaning it includes the insurer's liability as well as any member cost sharing. This approach normalizes for any differences in cost sharing by zip code, but does not allow us to adjust for any utilization differences related to product design by zip code. For example, if some zip codes had a higher proportion of members and high deductible plans which had an additional deterrent effect on members' use of health care services, we were not able to normalize for any such differences across zip codes.

The AGO obtained income information from the Internal Revenue Service. For each Massachusetts zip code, we obtained data on adjusted gross income and number of tax returns for the most recent year available, 2007. By counting joint returns as two and the remaining returns as one, we were able to calculate adjusted gross income per filer, for each Massachusetts zip code. There was no way to distinguish which filers had commercial insurance with one of the three insurers surveyed, other insurance or no health insurance, so while the TME data reflects the TME of commercial patients in a zip code, the income data includes residents with other sources of insurance, such as Medicare or Medicaid. For each insurer, we ranked the credible Massachusetts zip codes by average income and by average health status adjusted TME. Each ranked list of zip codes were grouped into five quintiles of equal size. For example, the 20 percent of zip codes with the lowest average TME, were grouped into TME quintile one, while the 20 percent of zip codes with the highest average TME were grouped into TME quintile five. This enabled us to analyze the distribution of zip codes by TME quintile and by income quintile, to understand if there is any relationship. For example, for the quintile zip codes with the lowest average TME, we calculated how many of these zip codes were also in the lowest income quintile. We found a clear pattern between health status adjusted TME and average income by zip code, with many zip codes being in the same quintile for TME as for income.

In addition to examining the distribution of zip codes across quintiles, we examined the distribution of member months across quintiles, analyzing the distribution of zip codes counts each zip code as an equal unit, while analyzing by member months takes into account the fact that some zip codes have more members than others. Both approaches yielded the same finding; a clear pattern between TME and average income by zip code. We chose to publish the distribution weighted by member months in our graphs, because that approach accounts for membership differences among zip codes. The data I have reviewed, examined from multiple perspectives, supports the AGO's findings that on a health status adjusted basis, the total amount spent on the care of commercial patients from higher income communities is higher than the total amount spent on the care of patients from lower income communities.

The AGO's analysis of TME and income is valid and reasonably relies on the information produced by insurers and obtained from the IRS. Thank you.

Karen Tseng

So the AGO and the division has outlined a significant problem here with these price disparities. What do we about it? Some recommendations. These findings on price disparities and their effects on the market and on health care costs are the result, both of increased transparency in the market and the rigor of our examination. We think that while it is very important that sound data and findings be brought to the attention of stakeholders, it is equally important that we as a commonwealth, find sound ways to act upon this information. As in any market, the purchaser, here consumers and employers, have a unique role to play in helping to improve market function. It's critical that consumers and employers have the tools to make value based purchasing decisions, both through improved information and through purchasing tools such as limited and tiered network products, which differentiate among providers based on value. Such tools should be coupled with other measures, such as the temporary statutory restrictions described in the Attorney General's report, to insure we move fast and far enough in right sizing this market and in addressing the problem of rising health care costs. That is critically important to businesses and to families across the Commonwealth. Thank you.

Seena Perumal Carrington

Thank you Stacey, thank you Karen. We received a few questions from audience members that I'll ask now. Either of you can feel free to answer. If the prices were not severity adjusted, would the variation increase?

Stacey Eccleston

I suspect that if we didn't perform the severity adjustment, actually the variation would be wider. And I say that because when we take a look at the hospitals, a lot of the hospitals that were on the higher end, did have higher proportions of patients that were in the severity levels three and four. So I think that without that severity adjustment, the variation definitely would have been wider, although it wasn't consistent so there might have been people that were moving around in different places, because there were in fact some hospitals in the middle or at the lower end, that also had that higher severity mix.

Seena Perumal Carrington

Thank you. There's a high usage of academic medical centers for routine and elective procedures. Thoughts about how consumers define quality. Maybe that correlates better with utilization and price. How do we change consumer perceptions of hospital brands?

Stacey Eccleston

It is true. I think that quality for the consumer is a lot about perceptions. And in fact, some of the measures that we used in our quality metrics were patient experience measures, and there's eight of those patient experience measures that relate directly to the care that they received while in the hospital, and then two are more or less about, so would you recommend this hospital and how would you rate it overall. And you can see sort of the patients' perceptions coming out in those questions, because there are sometimes hospitals that are sort of in the middle on all of those, did the nurse come and visit you, did the doctor explain everything, but then when it comes to those last two more perception related questions, all of a sudden there's a change in that it's highly rated. So I think that's a question that's going to be great, that we can talk about in the panel this afternoon, because we're going to be talking about how consumers view quality and what would motivate them to make better health care purchasing decisions.

Karen Tseng

Yes, we could add to that. It certainly starts with good information, making sure the consumers have access to well vetted and standardized information on the quality performance of providers that they are seeking care from, so that they can make an informed purchasing decision. In addition to reliable, well vetted and transparent quality metrics, starting with good information, one of the recommendations in our report is to highlight for consumers, the cost and quality outcomes of their choices, so they can see the clear link between rising premiums and choice of health care provider.

Seena Perumal Carrington

Is the conclusion that Medicaid pays too little, private payers pay too much, or somewhere in between?

Stacey Eccleston

I don't think there's necessarily a conclusion that comes out of that analysis, but I would like to hear also, the panel that's coming up next actually, maybe talk about that a little bit.

Seena Perumal Carrington

Why do you think providers with a high Medicaid percentage are paid on average, very poor rates by insurers, when insurers say they are making up for these deficits?

Stacey Eccleston

I think that's a similar question, but I've heard from those that look at that, that it's not -- you know, that it's those payers maybe that have high percentages of Medicaid populations that are not in the negotiating position to be able to negotiate the higher private payer prices.

Seena Perumal Carrington

That's your potential future research questions, but I'll ask anyway. I'd be interested in the comment on the potential for escalating disparities in price, given the rapid consolidation by providers. Let's consider regulatory mechanisms to prevent this, which would be engaged at the time of mergers and acquisitions prior to approvals.

Karen Tseng

And I think as you said, I think that would be something that we want to watch as time goes by, and then of course we'll accumulate more data over time as we see the reality of that.

Seena Perumal Carrington

Since low income citizens are generally on Medicare or Medicaid, and since it pays less, would it not follow, their TME would be less? It would be really helpful to look at this issue for private payers owners if that's feasible.

Stacey Eccleston

I just want to clarify that the graph you see here, examining total medical expenses and income, is for the commercial private health insurance market. It does not include the TME of Medicare and Medicaid patients.

Karen Tseng

I would just add I think to that point, we agree. It would be great to be able to take that as a next step and find a way to pull out the Medicaid and Medicare from our analysis, if that's possible. From the income data.

Seena Perumal Carrington

And this last question I believe is for your office. Why wasn't geography factored into the analysis? Costs are very different from urban Boston to central or western Mass. And similarly, our higher income consumers causing some of the discrepancy in prices, because they use more services or pick more academic medical centers?

Stacey Eccleston

I'll take the last part of that question first. You hit the nail on the head, that the cause of higher health status adjusted total medical expenses is found in using higher priced providers more often than patients who have lower TME, as well as using more services. So our findings would tend to suggest that those with higher total medical expenses here, the ones from higher income communities, are doing a combination of going to higher priced providers more often, as well as consuming more resources and consuming more expensive treatments or service mix.

Seena Perumal Carrington

Thank you. I want to thank both the Division of Health Care Finance and Policy, and Stacey's team in particular, and the Office of the Attorney General, for their analysis. We'll actually take a short 10-minute break before reconvening in this room at approximately 10:25, for the next panel discussion at 10:30. Thank you.

[END OF PART 1]

Seena Perumal Carrington

I would like to introduce Michael Bailit, President of Bailit Health Purchasing, who will serve as the moderator for this panel. And Michael, if you could join us at the front as well, and we'll begin by swearing the panelists and the moderator in. So if you could all rise for a minute. Do you solemnly swear that your testimony you are about to give in the matter now at hearing, will be the truth, the whole truth and nothing but the truth, so help you God?

[MODERATOR AND PANELISTS ANSWER IN THE AFFIRMATIVE]

Please identify yourself by raising your hand if your testimony today is limited for any reason, if there are any restrictions placed on the capacity in which you testify here today, or if you have any conflicts of interest that require disclosure.

James Roosevelt Jr.

I'm testifying as President and CEO of Tufts Health Plan, not as Board Chair of the Massachusetts Association of Health Care Plans.

Normand Deschene

And I'm testifying as the President and CEO of Lowell General Hospital, not as the Chair of the Massachusetts Hospital Association.

Seena Perumal Carrington

Please submit a written statement for the record, disclosing your specific restrictions or conflicts by July 7th. Thank you and then now we'll begin with Michael.

Michael Bailit

Good morning audience, response panel. I'd like to introduce the response panel and then we'll begin with some questions. A couple of them actually just introduced themselves. Normand Deschene is the President of Lowell General Hospital. Gary Gottlieb is the President and Chief Executive Officer of Partners Health Care. Jim Roosevelt is President and Chief Executive Officer of Tufts Health Plan and the Chairman of the Board of Directors of the Massachusetts Association of Health Plans. Andrei Soran is the Chief Executive Officer of Metro West Medical Center and Ellen Zane is President and Chief Executive Officer of Tufts Medical Center. Thank you all for being here.

I've got a series of questions and I'm going to rotate them around you as we go, and on a couple of occasions, I may ask a couple of you to respond to the same question. I'd like to begin Andrei, with a question for you.

Seena Perumal Carrington

Actually Michael, I apologize for interrupting. We allow the panelists to each provide five minutes of opening comments before we go into Q&A.

Michael Bailit

I'm sorry. No, I think I made the same mistake last year too. All right panelists, you each have five minutes to presents, so Norm, why don't you start.

Normand Deschene

Thank you. Good morning Acting Commissioner Carrington, members of the Legislature, Attorney General's Office and their representatives and colleagues. Thank you for asking me to speak today. I'm going to talk a little bit about the price variation in Massachusetts. As background, Lowell General Hospital is a 217-bed community hospital, located in the city of Lowell, the fourth largest city in the Commonwealth. This is my 27th year managing at Lowell General, the 8th as the CEO. I'm proud to represent this important community hospital asset and offer as an example of how balancing both cost and quality successfully offers an undeniable value proposition to the Merrimac Valley local employers and the insurance industry.

During my tenure at Lowell General, I've experienced firsthand, the evolution of the health care payment system, from cost based reimbursement to HMO proliferation, to pay for performance, and now to accountable care. Lowell General has been agile at adapting to this ever-changing landscape. Our successful evolution is based upon our unwavering core principles, which include compassion, service excellent, an unrelenting focus on quality, and nursing care, with an underlying focus on remaining affordable to our community.

The private payment system in Massachusetts clearly is a free market system and although there's no easy answer to the question, what causes wide variation, we also believe the greatest determinant is very evident. It is leverage, as defined by market position, location of brand name, has been the largest drivers of the disparity in rates. I do want to point out however, that the high focus on academic medical centers being paid more than community hospitals is misplaced. The focus should be on what level or degree the premium should be driven by tertiary care and how to create parody for low cost providers in the high quality community hospitals that are underpaid.

Academic medicine is one of the cornerstones of Massachusetts health care, and we appreciate and respect that fact and on any given day from the city of Lowell, at least five people are transferred to academic medical centers and we're grateful that they exist in the not too distance from Lowell. Nonetheless, the disparities in how we are paid needs to be addressed. There are lots of factors that limit the ability for Lowell General to contain costs, and one of those that we've been facing is that our PHO has been looking at the expansion of provider physician networks. The LGH PHO membership includes 80 PCPs and 200 specialists, and several PHO specialty groups have recently chosen to affiliate with tertiary affiliated provider networks in exchange for a higher fee schedule. This practice has been encouraged by tertiary related provider organizations and is allowed by many of the private payers. And to our knowledge, of these newly formed relationships, few have demonstrated little or minimal clinical integration or efficiency while primarily serving to drive up costs of care and destabilize the community based networks.

One of the unintended consequences of rate transparency is the highlighting of the vast disparities among physician provider schedules. The LGH PHO works collaboratively to maintain its network of physicians, while balancing the needs of our PCPs, specialists, and our community. Migration of any large physician group to other related networks results in increased costs, which undermines our risk arrangements and causes animosity between local PHPs and our specialists. We've always been subject to extremely competitive market dynamics in Lowell and as a result, we've had some of the lowest quartile reimbursement from private payers across the state. Approximately 20 percent of our revenue is from Mass Health and managed MCO payers, and another 35 percent from Medicare. LGH's lack of market leverage and its high governmental payer percentage, have required that we be highly efficient in the delivery of health care.

We are financially stable, we're in a growing market, and I've been able to spend significant capital in the last seven years. We've expanded services to include neurosurgical services, cardiac and vascular services, a level 2B nursery and level 3 trauma center. And by expanding this breadth and scope of services, we've kept more patients and residents local. So unlike the trends that were highlighted earlier, over the last three years, we've been very successful at increasing our market share by 8 percent and for the most part, all those patients have come at a savings to the Commonwealth, because they're coming or moving to us from higher cost institutions. We've also done something fairly unique in that we were one of the first community hospitals to agree to the Blue Cross Blue Shield AQC contract, a 5-year agreement between us and the payer, and we've performed extraordinarily well by dramatically improving quality scores and efficiency. The cost trend reductions that have been derived are because of several factors, including referral management, utilization management and managing high cost services and moving more cases back to Lowell. In addition, the PHOs worked with our physicians to develop programs to review utilization of high cost areas such as inappropriate use of emergency room, high cost imaging and other testing.

In conclusion, it's my belief that we have to migrate towards a system of global payment, with meaningful payments tied to quality and performance, service excellence and patient outcomes. The current fee for service system rewards production rather than outcomes, and bakes in the price in disparity and further builds the inequities between various sectors of our market. Although there's been some criticism of the global payment model, I urge everyone to be patient. Systemic changes to the health care delivery system must be given an opportunity to take root and should not be changed through a regulatory response which, to use a health care analogy, does little to address the causes but only addresses the symptoms. Thank you.

Gary Gottlieb

Thank you and good morning. Thank you for the invitation to speak on this important topic. At Partners Health Care, our mission is to provide the best possible clinical care to our patients and their families, to search for cures that can improve that care, and to invest in the education of the next generation of leaders. All of this is in service to the communities that we touch every day. We partner with our neighborhood supporting community health centers and making significant capital and other investments, to insure that the quality of care is the same for all of us. And we provide economic opportunity, creating career pathways for young people, community residents, as well as for our incumbent workforce.

Our system offers a full range of services across the entire continuum of care, from primary care to the very highest levels of intensive services. Last year, more than one in six of our patients, more than 14,400, were transferred to the Brigham and to the Mass General from other hospitals, in the hope that we could provide unique, lifesaving care. These are the sickest patients and there's a cost associated with providing this level of care, but it also speaks to quality in a way that no process measure ever could.

How do measure research and innovation? Doctor Bo Pomahac, Plastic Surgeon at the Brigham, has given four people their lives back with his remarkable work in face transplantation; a program that the Defense Department is supporting to save our wounded soldiers. Dr. Daniel Haber from the MGH, developed a test that can detect traces of cancer cells in blood samples, potentially opening the door to new ways of managing cancer, and our researchers have made vast strides in unlocking the secrets of Alzheimer's Disease. This work is a major economic driver and we are the core of the state's national leadership in life sciences. Nearly one in six adults in Massachusetts, nearly a half million people are employed in health care, and with more than 60,000 people, we are the state's largest private employer. Many more jobs are indirectly related to health care, which has been one of very few stable sectors in what has been one of the worst economic times in memory.

As we consider the value of our hospitals, let me address prices specifically. We don't negotiate prices for other hospitals, so I can only tell you how we get to ours. We work backwards from our margin target of 2 percent for the entire system. In doing this, we must balance across a number of factors; across the network of providers that make up our system, across the range of services that we provide, and across the range of payers that we do business with, both public and private. This margin enables us to achieve our mission. Higher reimbursements for services like cardiology and orthopedics, are often used to subsidize poorly reimbursed services like psychiatric and substance abuse care, but we remain committed to these programs when many other providers have closed beds because they were not financially sustainable. We don't set prices on an individual service by service basis. A narrow analysis that compares the price one hospital receives for a specific service, to the price of that service at another hospital, doesn't capture an understanding of costs or reimbursement. It is not representative of how prices are determined. It's more relevant to consider the range of services, as well as the pair mix and other facts, such as those that are recognized by Medicare. The dialogue over price variations would be greatly enhanced by an analysis that would include these factors and how health care prices are truly determined.

I'm particularly disappointed at the Division's report on health care expenditures, because that report completely ignores the impact of public sector underpayment on private sector prices. The report showed that minimal increases in spending on public sector programs existed quite simply because rates were cute. Price freezer or reductions created cost shift from one payer to another, and place upward pressure on commercial rates. North Adams, which recently filed for bankruptcy, is an example of what happens to a provider with a 65 percent public pair mix and doesn't cover the cost of care. Our North Shore Medical Center has a similar pair mix.

We also believe that more attention should be paid to the issue of why small group premiums continue to experience significant volatility, given that providers are paid the same regardless of the size of a patient's employer. We've been public that Partners recent rate increases have averaged 5 to 6 percent a year. The state should explore the difference between hospital and other provider rate increases, and the rate of small business insurance premium increases.

As I mentioned in my testimony last year, the greatest opportunity for rapid cost reduction is also potentially the most humane and patient and family centered. Analysis of Medicare data shows that 10 percent of beneficiaries account for approximately 70 percent of costs. These individuals are severely ill and many are near the end of their lives. Social, economic and behavioral challenges often complicate effective medical care and add significant costs. Findings are similar in other insured populations. Care for this high risk and high cost population is generally fragmented and often inconsistent with the best practices and the most effective use of resources. Therefore, developing and implementing innovative approaches to managing and paying for the entire care of this overall vulnerable population is absolutely crucial. At Partners we're tackling this issue through a Medicare demonstration project that we started at the MGH. The program integrates nurse care coordinators and other resources into primary care practices, to coordinate each patient's needs. The return on investment is high; for every dollar spent, the program saved $2.65 in health care costs. CMS renewed the MGH program and we've expanded the effort to two more Partners hospitals; Brigham and Women's and North Shore Medical Center.

We agree that we need to look carefully at the health care payment system, to determine whether it provides the right incentives or pays for the right things. That's why Partners has identified as a priority, a set of strategic initiatives, through a system-wide effort to redesign the way that care is provided, while making it more affordable for our patients and their families, and this will include thinking differently about how we should be paid for this work. The Division's report on price variation is only one step in assessing why hospitals are reimbursed differently from one another, and we welcome a more detailed examination of the issue as a special commission on provider price reform begins its work.

That being said, we should be careful not to overreact and overreach, especially on the basis of incomplete data and analysis. Nor should we over-promise the effect of reducing variation, which is not correlated with overall price or cost trends. We should resist interventions that might cause disruption in the health care system, less we jeopardize truly precious resources; critical services being closed, physicians choosing to practice elsewhere, a diminution of our ability to attract the best and the brightest young people and decrease in community investments. We need to insure that we make our system stronger, not weaker.

James Roosevelt Jr.

In the interest of time, I'm going to associate myself with Norm's greeting to all the distinguished participants here. On behalf of Tufts Health Plan, I thank you Commissioner Carrington, for the opportunity to testify at today's hearing, and I actually enjoy being in the midst, literally in the middle of so many high quality providers.

Tufts Health Plan insures roughly 760,000 members. Since 1979, Tufts Health Plan has been committed to providing a higher standard of health care coverage, and to improving the quality of care for every member. Tufts Health Plan's HMO and point of service plans are ranked third by U.S. News and World Report; NCQA and its Medicare Advantage Plan is ranked seventh in the nation. My testimony will address the current challenges and solutions for addressing variation in the prices paid for health services in Massachusetts. I make these comments, as I mentioned, in my capacity as CEO of Tufts Health Plan, and I don't speak for the Massachusetts Association of Health Plans.

First I would like to thank the Division of Health Care Finance and Policy, for releasing their 2011 health care cost trends reports. We agree with the following key findings of the price variation in health care services report. First; prices paid for the same hospital inpatient services and for physician and professional services, very significantly. Second, volume tends to be concentrated in higher paid hospitals. Third, there is little measurable difference among Massachusetts hospitals, based on available quality metrics.

I also commend the Attorney General's Office. We agree with the findings of the Attorney General's 2010 and 2011 reports. These three reports all reached the same conclusion; tremendous price variation persists and it is not explained by differences in quality or complexity of services. The Attorney General's Office reports and the Division's price variation in health care services report attribute these price variations to the size, geographic location, brand power and/or unique specialty of certain providers. We continue to be concerned about the level of consolidation that already exists and that continues to grow in our marketplace, and how it may further exacerbate the market power and price variation problem.

While some price variation is warranted, variation should not excessive and should be linked to quality and complexity of services. The Attorney General's report raises a very important point regarding the ability of the market to contain costs, based on the current dysfunction, which has led to distortions in price. The Attorney General's 2011 report suggests that immediate and temporary statutory intervention may be required in the short-term, to rectify unwarranted and excessive variation. We believe this recommendation deserves serious consideration. It is our opinion that unsupported price variation must be addressed, to truly rein in costs, but that any government intervention should not be heavy handed and that it should facilitate or compliment a transition to longer term, market based solutions. Once addressed, the greatest challenge we confront is the design of care coordination models, which engage providers and patients to concurrently reduce the cost of health care and improve quality.

Much has been written about the potential of new risk based, global based contracting models to solve this problem. In fact, the Attorney General's 2011 report states that a shift of payment methodology by itself is not a panacea for controlling costs, and that a shift without fundamental changes may not only fail to control cost, but may exacerbate market dysfunction and market inequities. We do not disagree with this finding. In fact, we view risk or global based arrangements as one piece of a complicated puzzle. These arrangements need to be paired with two elements to support its implementation. First; product designs that create the right incentives for members and providers as they seek indirect care, and second, clinical management programs that support providers who increasingly share employers goals of reducing health care cost trends.

At Tufts Health Plan, we have introduced something that we call the coordinated care model, which integrates all three components. The first component of our model is provider reimbursement. We are increasingly focused not just on how much we pay, but on the incentives these payments create for care delivery. We have developed a risk based global budget contract model that pays providers on their ability to manage the overall cost and quality of care. Since 2009, Tufts Health Plan has successfully increased the number of our commercial HMO members in a global budget model, from 18 percent to 41 percent. Our Medicare Advantage product has roughly 95 percent of its members in a similarly styled product that has been in place for over 15 years. There is no longer a typical risk based provider in our network. They include Boston based tertiary providers, along with community organizations. Perhaps the most important element that we must all consider in these arrangements is whether the budget or risk based arrangement, is affordable. I stress affordable, and not simply a perpetuation or institutionalization of the president price disparities.

The second component in our coordinated care model is product design. It is the health plan's job to develop products that provide the member with the right incentives to engage their PCPs. For example, if a member needs a consult from a specialist, they should have an incentive to engage with their PCP and explore whether the community cardiologist can provide the same or higher level of care, without the cost of going downtown. We believe our limited and tiered network products provide these incentives. The price differential for our limited and tiered network products ranges between 14 and 16 percent, when compared to our traditional broader network products. We believe this premium differential, combined with co-payment options, provides the right incentives for members and providers as they seek in direct care. But it is not simply about product design. We must design products that support the administration of risk based or globally based arrangements, and if in the process they also provide lower cost providers with increased referral volume, we will have achieved a dual objective.

The third component is care management. Our approach to care management comprises three strategies; direct management of utilization to reduce waste, management of conditions and diseases, and a focus on health and wellness. A major function of a health plan is to routinely monitor for under-use and overuse of services, and work extensively with providers to monitor the quality of care being delivered. We have also created a variety of clinical programs designed to reduce unwarranted utilization and variation in the delivery of care. One of our care management programs is under return of investment of $1 spent to $4.80 saved. We have also created tools to support member and provider engagement in health and wellness initiatives.

In a fee for service world, we have helped members manage the type of services they receive, sometimes identifying points of under-care, other times helping with transition to other lower intensity places of services. In a world of aligned incentives, we have a different opportunity, and that is to develop programs which compliment or support those programs the provider may already offer. We all agree that the physician or nurse is in the best position to coordinate the care of patients when they are equipped with the right tools and provided the right incentives. We believe these three variables; provide a reimbursement product design and care management, should be brought together as they are in our coordinated care model. We view risk as a key enabling factor but believe it must be complimented by other areas of organization to be successful.

In conclusion, as the reports show, price variation is a problem that needs to be addressed as we attempt to control medical costs. While a temporary statutory intervention may be required in the short-term, we believe market based solutions such as our coordinated care model, hold great promise for long-term improvements in both quality and efficiency. We look forward to working with state agencies, legislators, employers and providers, on ways to address the Commonwealth's unsustainable health care cost trends.

Andrei Soran

Good morning. Thank you for inviting me today. I represent Metro West Medical Center. We're an investor owned community teaching hospital system, having two campuses, numerous satellite and outpatient facilities. Metro West plays a critical role in the Metro West Community. Beyond providing medical care to thousands of patients, many without the adequate insurance coverage, Metro West is a major employer of local residents and supports various community organizations that share the mission of caring for those in need. We employ 2,500 local residents. We pay more than $1.7 million in real estate and personal property taxes, $1.2

million in sales taxes to the Commonwealth of Massachusetts, while providing free care worth more than $3.5 million a year. We belong to Vanguard Health Care Systems that owns 26 hospitals in various locations in the country.

I applaud the groundbreaking work done by the Division of Health Care Policy and Finance, and the Office of the Attorney General, in their recent reports. They describe the challenges that my hospital and others like us across the Commonwealth, face as we attempt to fulfill our mission. We face significant financial pressures. At the center of this financial challenge is the reality that we and our peer institutions are inadequately reimbursed for the high quality care we provide. There are wide variations of rates for reimbursement to hospitals for the same services, and these variances are a driver of unsustainable health care cost increase.

The more highly paid hospitals and medical groups are using this advantage to grow, at the expense of lower priced providers who are losing volume. Higher rates of reimbursement allow the more fortunate providers to pay better salaries, to attract and retain staff and doctors. They allow for better, newer equipment and facilities, creating marketing advantages. They also fuel expansion plans, further encroaching in new territories at the expense of lower paid providers. Metro West is reimbursed on average, 25 to 40 percent less than other hospitals in its service area, for the same services, with little or no difference in quality. As a result, the burden of operational improvements further erodes any margin, limiting the ability to invest in facilities, new programs and staff, and threatening Metro West's ability to continue to provide comprehensive range of services in the Metro West region for the long-term. Without access to our hospital, patients will be forced to travel greater distances to obtain care, at significantly more expensive hospitals, raising everyone's overall insurance costs. For businesses, town, cities, labor unions and increasingly consumers who are paying the bills, this will mean unnecessary higher cost and out of pocket expenses.

Our paramount focus is the safety of our patients. I believe we do an excellent job, and this was described in the reports. I would also say that since the data is not very current, we took the liberty of submitting in our testimony, the trends for quality and service at Metro West Medical Center, and I'm happy to report that at least in the quality measures, we're in the upper 15 percentile in the country. However, payment has not kept up with the increasing quality and service that we're providing.

Disparities in payment to physicians have also created systemic stress at local levels. It makes no sense for primary care providers to experience disparities in payments, up to 30, 40 percent, while living and working in the same community, serving the same kind of patients, and providing the same king of care. In addition, the affiliation of those providers with powerful networks, with higher reimbursement institutions, creates a flow towards the higher cost hospitals, further weakening the local units of care. With your indulgence, I would suggest some solutions.

Allow integrated system and providers to directly access employers and offer attractive prices in exchange for higher utilization of their resources. I will share an example of what we're doing at Metro West. Insure the large system, such as Partners, (inaudible), allow medical information exchange with other providers. The exclusivity of data control prohibits efficient care at the local level. Regardless of a design of the limited care networks promoted by insurers, without the information, care will not transfer to lower cost providers. Creating steps on the way to ACOs. The difficulties in managing risk can be mitigated by allowing development and payments for a bundling of high cost conditions and medical models. I would like to further address this during the Q&A.

Understand for providers to be assigned higher level of risk infrastructure is needed. The role of insurance would change or diminish and the funds will transfer to providers. The cost containment measures contemplated by different regulatory and pay organization, should not only seek to reduce payments to the haves. They should also balance or seek to balance their payments so the effective and efficient providers can maintain and grow their operations. Some of the recommendations in the Attorney General's latest report supports some of those solutions.

As I mentioned, we are working to insure the viability of our hospitals in the current environment in a proactive way. The real value of high quality, high service, low price, it's something that we believe can provide a value proposition to the market. For example, subscribers of -- the Group Insurance Commission recently announced that 30 percent of the 58,000 active state and municipal employees that they have enrolled in what they describe as limited networks, plans that favor the hospitals like Metro West. Several private employers have adopted tier plans that also favor the use of enhanced tier hospitals like Metro West. For example, Polar Beverages has experienced a 250 percent increase in utilization of our hospitals, while decreasing their cost because of our enhanced tier, as opposed to alternative basic tier hospital. The alteration in cost per member will create an opportunity for Polar Beverages to negotiate lower premiums at its next renewal.

The longer the disparities continue, the more the costs will increase. The high quality and low cost providers will diminish their market share, therefore increasing the cost to the total system. Thank you.

Ellen Zane

Thank you. Good morning and thank you for the opportunity to testify with some of my august colleagues today. I would like to commend you Active Commissioner Carrington, along with Governor Patrick, his administration officials, the Attorney General and the Legislature, for recognizing this critical issue and for continuing to insure it remains a priority for us all. I would specifically like to commend the Acting Commissioner and the Attorney General, for continuing to investigate and report on aspects of the health system that have been in dire need of transparency. These reports astutely point out the areas needing greater scrutiny and change and a course of action.

My comments today are remarkably similar to those I made last year, because a year later the market is remarkably the same. I believe it is wishful thinking to say that the market is working by itself. It is not. The recent set of reports from the Attorney General and from DHCFP, clearly demonstrate the price is still a major cost driver in the market, that huge price disparities still exist, even among globally paid providers, and that there is not one silver bullet that will resolve the inequities and reduce health care costs. The DHCFP reports show that many patients continue to get treatment for the most common conditions at the most expensive providers. Any medical center search for quality metrics that justify the highest rates, will never justify the degree of disparities in our market.

Solutions must include a move toward correction of the wide and baseless disparities among health care providers that disappointingly still exist today. In addition, employers and all consumers must have incentives for selecting high quality, value priced hospitals and physicians. Furthermore, providers who treat significant populations of Medicaid patients, must not face discriminatory pricing from the insurance companies. We are not looking for a race to the top, but we can never support any approach, I will never support any approach that bakes in the disparities and further punishes those who serve higher levels of Medicaid patients.

Let me tell you a bit about Tufts Medical Center so that you better understand my perspective. Tufts Medical Center has the highest case mix index of all full service hospitals in the state of Massachusetts, and despite its unusually high, complex population that we care for, the quality of the care we provide is among the best in the city of Boston. By virtually every measure of patient care and outcomes, we are as good or better than our fellow AMCs. Approximately 25 percent of Tufts Medical Center's population is insured through Medicaid, making us the second largest Medicaid provider in Boston, and demonstrates we provide nearly triple the Medicaid services than other AMCs in Boston, with the exception of Boston Medical Center. We are not paid slightly less than our highly respected competitors, we are paid significantly less; 30 percent to 70 percent less than our competitors. And the amazing physicians who care for our patients are paid 25 percent to 75 percent less than their colleagues in our town and around the state.

Tufts Medical Center and NCQA, our physician network, by virtue of our high quality and lower costs, is part of the solution to rising costs in this market and is not part of the problem. From where I sit, I believe the following measures must be taken as part of this problem. First; price convergence is imperative for a healthy and sustainable market. Last year, the Attorney General brought to light, the staggering payment differentials in the health care market, and the leverage wielded by our best-known or geographically isolated providers. A provider's quality, mission, case mix and share of publicly insured patients does not appear to be driving prices set by insurers. The most highly paid providers continue to hold massive unfair advantages when it comes to physician recruitment opportunities, technology acquisition, marketing dollars, brand recognition, cross subsidization of undervalued services like mental health, and overall consumer awareness. With no incentives to direct them toward high quality, lower cost providers, consumers continue to flock to expensive providers, as they have no need to think otherwise.

As the Attorney General points out in her latest report, global payments alone are not addressing rate disparities. These most recent reports show providers who have significant market leverage, have been able to use it to secure high global payments, just as they always have to secure high fee for service payments. I believe there are several factors that must be considered when addressing these outcomes regarding disparities. Not all systems are equally efficient. New payment systems should not reward organizations with higher total medical expenses, and they should not punish already low cost providers by baking in the disparities. Providers must be categorized and analyzed for efficiency, quality and payment by peer group for true apples to apples comparisons among institutions. Only then can we determine appropriate payment rates, which should be at least at the average of others hospitals in the market's peer group. This means academic medical centers and community hospitals are not the same and should not be categorized as such.

You all know that Tufts Medical Center and NCQA are participating in Blue Cross's alternative quality contract product and have had a positive experience and believe it needs more time. But for global payments to bend the long-term trend in health care spending, and to provide a viable surplus to all providers, some recalibration is required. Several factors should be recognized and differentiated prices are, quality. Providers should be rewarded for meeting quality standards. Efficient care management. Providers should demonstrate efficiency in treating patients and should not be penalized by well below market rates. Safety net services offered and Medicaid mix should be recognized and valued. Acuity. The severity illness treated by a provider needs to be incorporated. And teaching status. All academic medical centers bear a significant burden in training the next generations of physicians and caregivers, as well as maintaining a higher level of critical services.

Simultaneous pursuit of alignment of consumer and provider incentives is essential. As stated in the AG's report, it is unlikely that consumers will respond to data about cost and quality of providers unless they are prompted to do so by their insurance plan design, that encourage them to seek out low cost, high quality providers. I agree wholeheartedly with the Attorney General, that limited and tiered networks are the best ways to achieve this incentive alignment. Consumers who responsibly choose lower cost, high quality providers, should be financially rewarded with lower co-pays and premiums.

Government underpayment must be addressed. The ever diminishing level of government reimbursement in the face of increasing government mandates, forces providers to try to charge more to the private sector, or to simply endure the reduced reimbursement from the state contracted rates. Often, it is the latter, because providers with the highest Medicaid populations are also among the most poorly paid by commercial insurers as the DHCFP report shows. More than a quarter of Tufts Medical Center patients are on Medicaid and we continue to receive much lower commercial rates than our peers for no reason whatsoever.

You've heard me say that there is no silver bullet and there must be an all hands on deck approach; providers, insurers, government, employers, consumers, all need to be in this game. We will all continue to be disappointed and we will all look for one culprit or one silver bullet, and it will not work unless we all recognize that we all have a responsibility in the answer.

Michael Bailit

Thank you all panelists. So I'm ready now at this time, to start again. Actually Ellen, I'm going to start with a question for you. Marketplaces typically have -- when I say marketplaces I mean marketplaces in general, typically have a fair amount of price variation. So why is price variation a problem in health care? We typically don't have hearings about price variation in napkins or other consumers goods and services, why is it an issue here?

Ellen Zane

Well, we're also very highly regulated and we also have consistent missions. The price variation in napkins, I think you said, is not mission driven. But however, for those of us in academic medical centers, we have tripartite missions that we do need to cross subsidize, and we need, in a market like this, to value that. We are training the next generation of physicians and as Dr. Gottlieb said, we are all working very hard to be on the cutting edge of the medicine of tomorrow, and those are missions that need to be supported in a market like this. So the price variation means that some people can support those missions and some people cannot, and that is not in the best interest of a community like this, that has the crown jewels of medicine within it.

Michael Bailit

Norm, what would you add? What's the problem with having variation in prices?

Normand Deschene

Well, I think the problem is that it creates a system where those hospitals that have higher prices, tend to have greater resources, that compete with hospitals that don't have those high prices. We compete for labor, we compete for materials and patients, and I think in the end, as has been indicated here, marketing, budgets and facilities and others things, those hospitals that have higher rates, they're able to funnel more money into those things, putting those hospitals that don't have that money at an unfair competitive disadvantage. That results in over time, a dwindling number of those hospitals or weaker hospitals, and could end up in further consolidation into a few systems that have much higher rates, at the expense of a system that currently exists, of having lots of small community hospitals that have lower rates.

Michael Bailit

So to paraphrase, the disadvantage to consumers or to citizens of the Commonwealth, is that if we have a lot of disparity and you can't continue to thrive or you can't serve your mission Ellen, then we'll have fewer systems and the fewer systems will be pricier and so cost will be higher to the Commonwealth?

Normand Deschene

Yeah. If you go back to my testimony, I indicated leverage was the greatest determinant and indeed, if the Commonwealth is left with three or four systems in which all hospitals are members of, then the leverage of those systems is going to significantly increase and I think we'll see a further escalation of those costs.

Michael Bailit

Andrei, what drives price variation?

Andrei Soran

I will apologize upfront for the comparison, so please remember when I make this, it is not because health care is not different, it's very, very different. I think the root of the problem is the expectations. Both reports; the Division of Insurance and the Attorney General, has extensively analyzed the quality and in some instances the patient satisfaction. So the expectation of our consumers is to get the Cadillac. In other industries, you can't survive if you provide another brand. So when the expectations are so high and the variation in cost exists, people cannot compete on an equal playing field. There is cost baked in that people cannot fulfill when somebody has an unfair advantage.

If our industry would say -- you know, you show up at the hospital and you have a sudden condition, you may make it or you may not make it. It's a matter of cost, that's not the expectation. You go to a downtown hospital or you go to a community hospital and you expect the same outcomes.

Michael Bailit

I understand that, but I'm interested -- you know, we've got the charts over here actually, which none of us can see, but charts over there that show the range of prices. I'm interested in why do we have such a big range. What's driving that?

Andrei Soran

Market power.

Michael Bailit

Is it just market power? Market power is 75 percent? What would you estimate? Is it only market power?

Andrei Soran

You know, I think that Norm also mentioned this. There is no doubt that an academic medical center can provide services that a community hospital does not provide and should not provide.

There is a certain level of difference that should be baked in. There is no reason that my neighbor hospital six miles from me that has equality, equal service, and same doctors, is getting paid 40 percent more. So if it's not market power it's what?

Michael Bailit

Jim, a question for you. Are there justifiable reasons for price variation and if so, what are they?

James Roosevelt Jr.

There are justifiable reasons for price variation and they are a difference in quality or complexity of services. There are unjustifiable reasons, which I think the data shows we are also subject to, and those can be size, geographic location, brand power. I think we need to enable both consumers and payers to distinguish among those causes. If you think about quality and complexity of services, I expect to pay differently for dinner napkins on the rare occasions that I use fancy dinner napkins, as opposed to the ordinary napkins that work just as well at the breakfast table. And I expect to pay even differently for wet naps. And I think you have to try to transform to a system that makes the distinctions about the quality and complexity of services.

Michael Bailit

So, should prices be the same, except for differences in quality and complexity?

James Roosevelt Jr.

Prices should -- I believe that in a truly informed market with properly designed incentives and product choices in terms of coverage, prices would converge.

Michael Bailit

So very minimally if not be the same. Is that what converge means?

James Roosevelt Jr.

Yes. With differences based on quality and complexity of services. I think it is important to recognize something that Dr. Gottlieb referred to; you can't look at prices just per service. You do have to look at what the institution is providing, because at least as currently designed, there are services that will be and must be subsidized by other services.

Michael Bailit

Okay. So let me just stay with this a little bit further. So if we've got some good way of case mix adjusting payments, and let's say you're making payments to Norm's hospital and to Andrei's hospital. If Andrei's hospital happens to have higher quality scores than Norm's hospital, then the price should be higher at Andrei's hospital.

James Roosevelt Jr.

Yes. I'm making kind of a leap of faith there, that there are costs to increasing that quality.

Michael Bailit

Now there does seem to be assumption that quality costs more, right?

James Roosevelt Jr.

And I don't think that is -- overall, I don't think quality necessarily does cost more, but it might be that there are, in terms of having a particular level of expertise available or something, there are costs involved.

Michael Bailit

But quality might sometimes cost less too, right?

James Roosevelt Jr.

I believe quality can definitely cost less.

Michael Bailit

Fewer errors, more efficiency.

James Roosevelt Jr.

Fewer readmissions, those sorts of things.

Michael Bailit

Gary. So I asked Jim about whether there are justifiable reasons for price variation. Are there unjustifiable reasons for price variation?

Gary Gottlieb

First, I can't speak well to price variation, because I sit on one side of the table and the payers sit on the other side of the table. So as I mentioned in our negotiating our rates overall, we don't focus on other people's rates; we focus on how it is that we can get to be able to achieve our mission. I think the differentiation issue around quality that Jim was speaking to, I think are important. But as the Attorney General's report indicates, we're still very largely dependent on process measures which, as all the data showed, can't distinguish among providers very well at the present time. We haven't done enough good work over the years that people like us have been engaged in health services research that could have come to better conclusions.

Michael Bailit

I'd like to talk about the issue of how good are our quality measures, but I'd like to stay on my question though. We know there's a lot of variation and obviously, you only negotiate for your hospitals. But given that there is a lot of variation, I'm interested in whether there's justified variation and whether there is unjustified variation.

Gary Gottlieb

I think that taking advantage of hospitals that don't appear to have specific strength, and not paying them adequately for their services relative to their mission and the service that they provide in their community is unjustifiable. The prices that are described here, that are not covering costs or that essentially don't allow individual hospitals to be able to be capitalized, to be able to provide better services that are patient and family centered, to be able to adapt information systems that provide the state of the art of safety, are in fact unjustifiable variations in prices.

Michael Bailit

What you're saying would seem to suggest, at least to me, that to the extent that prices are set, they should match what costs are, whatever the cost might be.

Gary Gottlieb

Prices should be set based upon an understanding of the full range of services that are provided and necessary for both the institution and the community that it serves, and the expectations essentially, that the community has in the ability of those providers to provide those services, as well as clearer measures of quality and the ability to deliver on the stuff that's necessary.

Michael Bailit

Let me take a question that has nothing to do with your system. I'll take Norm and Andrei again, please pardon. Norm and Andrei, let's say that their price is over the commercial payers in the state, vary by 30 percent, and they're delivering essentially the same services and as best we know, with the same quality. Is that justifiable variation or unjustifiable variation?

Gary Gottlieb

I don't know what the geographic differences are in terms of the labor markets.

Michael Bailit

Well let's assume too, let's assume just for case of this example, geographic differences don't account for any differences.

Gary Gottlieb

You know, it's hard for me to understand what justifies differences in markets. As you pointed out to start with, there are price variations in every market, for every good, and additionally, although it was understated, there are price variations in every geography around health care providers. Even in those very highly regulated like Maryland, there are significant price variations among those providers. So how those evolve over a period of time, it's hard for me to determine some moralistic approach as to what's justifiable and what's not justifiable.

Michael Bailit

So does that mean we should accept variation. And I'm not making any (inaudible), but I'm just trying to understand what you're saying. Is variation not a problem then, or is it so intrinsic to a marketplace that we just have to accept it because it's part of what a market --

Gary Gottlieb

I think it is likely there is going to be variation. I think what is unjustifiable is underpayment for high quality services, and that that underpayment needs to be recognized as a significant problem that will harm institutions and harm communities.

Michael Bailit

And can there be such thing as overpayment, or just underpayment?

Gary Gottlieb

Absolutely, there could be overpayment.

Michael Bailit

My next question that I'd like to ask is for Jim. Jim, why do you pay significantly higher prices to some hospitals than others, or to some medical groups than others?

James Roosevelt Jr.

Sometimes higher payments are for just exactly the reasons that I'm arguing are the right reasons here; greater complexity. And to the extent that we can measure it, greater quality. I'll say more often, greater complexity and sometimes, because of cost shifting, that is underpayment by governmental payers. We tend to not talk about one of the elements that when we talk about all the successes in universal coverage, we tend to not talk about one of the elements that has not been a success, and that was the commitment state to significantly increase its payments to Medicaid providers that dropped by the wayside in the budget crisis. So those are factors.

Sometimes we pay higher payments because of market power, because we are in negotiations and whether that is because of the academic nature of an institution or whether that is because of the brand reputation of a group of institutions, or whether that is because of geographic location, sometimes we pay higher payments because of those factors.

Michael Bailit

What would happen if you went to your contracted network and said, we're basically paying the same for all of our physician services and all of our hospital services, except we're going to count for differences in intensity of services based on the population served, and let's assume for now, the quality costs more so we're going to pay more for quality. What would be the response of your network?

James Roosevelt Jr.

We do that in a fair number of our negotiations and some providers respond enthusiastically to that. Some providers respond with growing accommodation to that.

Michael Bailit

Ellen, how would you respond if Jim said, I'm paying you the same as everybody else, except you've got a higher case mix, which you just told us about, so I'm going to adjust you for that but that's it. Otherwise, let's say your [cui?] looks exactly the same as everybody else, so you get the same payment as everyone on the panel.

Ellen Zane

Well I'd like to adapt that to something that I think is more usable than your question. And that is, I fundamentally believe a real fix in this market is to have a common fee schedule across all health plans. Not that we're all rate -- we're not talking about intense rate setting, but that fee schedule should be moderated with inflators, in private negotiations, not state run negotiations. Private negotiations. So perhaps the hand of the state could come in and develop a foundation that's transparent, that we all know the basis of, that isn't different from health plan to health plan. And then in our private negotiations, we talk about the issues you raised Michael and that Jim spoke to, whether it's the fact that we have a high Medicaid population or a high case mix or a teaching mission, all of which are legitimate variations in price.

So I think rather than talking about what's fair and what's not fair, we ought to do it more scientifically and we ought to do it more transparently, so that we have a common understanding that's irrefutable, and then we inflate it based on who we are, what our quality is, what our mission is, and so forth. And there's been a resistance to even thinking about that and I frankly don't know why.

Michael Bailit

All right, well your timing is good, since we got the new Price Reform Commission to talk about new ideas. Andrei, Jim's selling new products, narrow network, tier network products that frankly, I think never sold in Massachusetts for a long time, until just recently. If they proliferate, will that essentially address the problem of variation in price, and can we all go home and say the market's taking care of things?

Andrei Soran

You're referring to the limited networks? You know, for the first time in Metro West history that I'm happy I'm a low cost provider. I will take the 30 percent up any day, but the market is changing. So we're very happy that we're included in those networks and we see a change in the volumes on the referrals, but frankly, this is kind of a work around. It is designed to work around the disparities and I think a more global solution with variations, so having still a free market of sorts, it's a better solution. So for the interim, this will shift the market a little bit. I mentioned in my remarks that access to information, it's power, and that actually limit some of the penetration of those limited networks. It's not going to level the market. The shifts in volume are not sufficient to counter the differences in payments. You know, some of the remarks here about the margins of hospitals, we're talking about 2 percent, 3 percent, when you have 30, 40 percent differences in payments, it is very significant and I don't think it's going to be all covered by the limited networks.

Michael Bailit

So let's follow-up on hospitals and margins and such. Gary, the hospitals in your system, generally speaking, according to the graphs there, have prices that are higher than other hospitals, and you've indicated that you budget for a margin of 2 percent. I was going to ask you why your prices are higher, but because you budget for a margin of 2 percent, I guess instead I'm going to ask, why are your costs higher I'm assuming that that's what you would say is driving your prices being higher, but if I'm wrong, don't let me speak for you.

Gary Gottlieb

I think that there are probably several reasons. Again, I don't know how the other prices are arrived at. I know if the result is a 2 percent margin and our prices are higher and his margin is higher than ours and he has lower prices, from what you are saying, that those costs are higher. I think there are a variety of issues. One is that as each of us has described, we have a pretty broad base mission. That mission includes pretty extensive investment in our communities, the communities that our hospitals have lived in for long periods of time. I think we all invest in those communities and we essentially budget for making substantial investments, including the six community health centers that we own, five or six, as well as those that were affiliated with the capital expenditures we make there, as well as an investment in training in science, which are each critical elements of what our mission is.

We have essentially, in budgeting, in so doing, focused on the investment and safety, basically over the course of the last decade, on the efficiency and safety sides, since really crossing the quality chasm became the watch word for health care redelivery. We've invested in information systems in a way in which it essentially required our entire network to adapt to them before those requirements existed, before. Focused on error reduction with computerized physician order entry and electronic medication administration record, and engaged with the payers in discussion and incentives around the implementation of those safety mechanisms, as well as reductions and creation of efficiency in those processes. Those have created some of the basis for our cost and the investments that were related to them as well.

Michael Bailit

What about labor? We've heard some stories here about community providers that are losing staff and physicians because they don't pay as well as somebody else. I was with a primary care practice a couple weeks ago and they said they lost a primary care physician, who went to a Boston teaching hospital. Not yours, but went to a Boston teaching hospital because the physician was going to get a salary of 30 percent higher. Is higher labor costs -- and I assume a lot of your costs are labor.

Gary Gottlieb

That's (inaudible) percent of our cost of labor, right. I don't know that our labor costs are higher or lower, relative to each of the individual hospitals, relative to our prices, I can't speak to that directly. I know when I look at salaries for unionized employees, when we go to negotiations, that they're at the higher end in those categories. Our physician, I don't believe -- essentially, our objective around our negotiations, starting years ago, when there was substantial discussions here, in and around this marketplace about the loss of physicians to other markets. Our competitors, like others here, are not just here in Massachusetts, they're throughout the country, was to get our physicians to rates in terms of their salaries, that were comparable, so that they wouldn't leave Massachusetts. On the other hand, I can't tell you that our salaries for primary care doctors are significantly greater than others. I don't know what those are, but that hasn't been a major focus.

Michael Bailit

I'm picking up that there's a little push and pull, that community providers are losing staff to those who can afford to pay them more, and your competitive concern is you're losing your staff to perhaps providers in other states who can pay them more.

Gary Gottlieb

I think that that's what kind of set the benchmark for where we started to move our negotiations. Really, back more than a decade ago, right after the Balanced Budget Amendment, when we heard really from the Secretary of Health and Human Services, who said that in our marketplace, our payments from private payers were in fact disparately low relative to other marketplaces, and we were over-dependent on the Medicare system.

Michael Bailit

All right. You talked a little bit about why you think your prices are high. I'll leave it there.

Gary Gottlieb

Or how it is that we establish what it is.

Michael Bailit

How you establish them. Norm, your hospital looks quite different in comparison to Gary's, at least in the analyses that the Attorney General's Office has done and that the Division has done. As I looked at the data in the report the Division recently released, you fall at the bottom quartile or centile and more often centile, for a lot of the 14 procedures that were reviewed. And I noted that in addition, on your quality measures, you tend to look just about like everybody else on those measures. And finally, I looked at your annual report and you actually made a bigger margin than what Gary budgets for. So can you explain to me how price variation works such that you can be one of the lowest paid hospitals on a case mix adjusted basis and yet, you're generating a positive operating margin.

Normand Deschene

Thank you for recognizing that. I think we've always been, we've historically -- I think a lot of the reimbursement system in Massachusetts has historical roots. A lot of our rates are historical, they date back to Chapter 395 and rate setting before that. When we went to a free market system, the basis of rates were basically tied to that historical basis. And so the Merrimac Valley has been historically, one of the lowest paid sections of the state. Most of the hospitals in that region are lower paid. There's been a tremendous amount of competition and that competition has resulted in a lack of leverage in negotiating better rates, and so we've been I think, pretty agile at living on a very limited budget and at the same time delivering highly efficient, high quality care.

Michael Bailit

So, should your rates, your prices, be any higher?

Normand Deschene

Yes.

Michael Bailit

Why?

Normand Deschene

Because I'm delivering a fantastic product.

Michael Bailit

But making a positive operating margin with it.

Normand Deschene

Well, a positive operating margin but still, that margin is not large enough to allow me to compete on the same scale with others. I do have a discrepancy in what I'm able to pay our physicians and/or our employees. We are and have had troubles around capitalizing the institution and keeping up with technology, and at the same, we've had to make the same investments necessary to keep and grow our market.

Michael Bailit

Although you do have a big capital crunch going on right now.

Normand Deschene

We do, we do. And what we've been successful is moving and keeping more people in Lowell. As I mentioned before, going with an at-risk contract, that gave us some additional incentives to improve quality, improve efficiency, and insure that we had more people who were formally leaving Lowell. Lowell had about a 40 percent out migration rate. That means that every person in the greater Lowell area who was hospitalized, 40 percent of them were hospitalized in facilities outside of Lowell. For every time we keep one of those patients at Lowell General, because we are one of the lower cost hospitals, we're saving a significant sum of money.

Michael Bailit

I just note that because you seem to be doing okay despite having the lowest paid rates, that it draws into question, in terms of answers, and we're going to talk a little bit about answer later, that the answers may not always be that the prices need to come up. And I'm not saying that they don't need to come up for you but clearly, you've been able to succeed despite having some of the lowest.

Let me take a couple questions from the audience, and there have been plenty of them, and then I want to ask you a little bit more about potential solutions. If I can't read the handwriting, then I'm skipping to the next one. Why do you think providers with a high Medicaid percentage are paid on average, very poor rates by insurers, when insurers say they are making up for these deficits. Ellen, do you want to take that one?

Ellen Zane

Sure. Because I don't believe insurers are making up for those deficits. I think it's the conventional wisdom, I think we talk about that a lot, and I think there's some genuine attempt to talk about it and think about it but the proof is in the pudding. And the proof shows that the highest Medicaid providers are the lowest paid on the commercial rates, that's what the data shows. So I think we need to be more clear about what the truth of that is. I really don't think it's a conspiracy where people are trying not to address that, but I think it has been under-revealed, and now that the data is open, we need to address it.

Michael Bailit

Jim, you said that you thought that this was a reason, something that was influencing your rates.

James Roosevelt Jr.

Cost shifting is definitely a factor in price negotiations. It is also true that the other factors that we've talked about are present and that in some cases, not only will a hospital with high Medicaid usage not have some of the other leverage factors in negotiations, they also will have just a very small number of private payer patients and therefore, not have that be a significant part of the consideration for either the payer or the provider in those price negotiations.

Michael Bailit

Understood. Is it cost shifting or is it -- I don't know the right term, cost rising. Karen shared information in the prior session, that MedPAC had found that hospitals with high commercial rates tended to have negative margins on Medicare, which would suggest that the high commercial rates allow them to support higher costs and that's why, at least to me, that's why they were losing money on Medicare. So is the issue truly cost shifting or is it that your higher rates are allowing the providers costs to rise?

James Roosevelt Jr.

Probably both.

Michael Bailit

Let me ask another question, just off the top but it's legible. Do we have too many AMCs which are producing a national product, new physicians that our local employers and consumers can no longer afford? Gary, I have to ask you to respond to that.

Gary Gottlieb

I think that the way in which we are paying for the training of physicians is distorted in the fact that it passes through indirectly, through Medicare, and then there's the expectation of cross reimbursement from other sources, is problematic. Clearly, every projection is that we have physician shortages, substantial physician shortages, as access improves. I mean the great gift that we've created here in Massachusetts is an improvement in access in some dimensions. Certainly not in mental health services and in other underpaid services, but in a variety of other areas where there clearly is an improvement of access. As we improve access nationally, there's demonstrable evidence of both primary care and a variety of other specialty shortages. The institutions here collectively, have been major resources throughout the country and are seen as those major resources, essentially allowing us to retain quality here, as well as to be able to essentially be part of a system of academic health care that sustains and supports training.

Michael Bailit

Jim, why have plans, or we'll just say your plan so you're just speaking for yourself. Why do you agree to pay for brand reputation and geographic isolation, rather than rewarding quality? How can we fix this problem?

James Roosevelt Jr.

We continually, in our negotiations and in the structure of our provider payment contracts, attempt to increase the emphasis on quality. However, these are market negotiations and we do need to come to agreement in order to maintain networks and to compete for members and clients. What you see is the overall effect of all those factors in the market.

Michael Bailit

So if you don't pay for brand, you lose a hospital from your network and then you can't compete, because you don't have the hospital or a physician group in your network?

James Roosevelt Jr.

If a hospital has a particularly strong brand, it may be essential that that hospital be in our network, and in particular in our broad network. As you know, and somebody may have alluded to, we did pioneer a more limited network in eastern Massachusetts. It's not been terribly popular. Now there appears to be some shift in the market, particularly led by the Group Insurance Commission, to sort of a new approach and a resurgence. Tufts Health Plan started out as a narrow network plan entirely, remained very, very small, as long as it was a narrow network plan. There are hospitals that consumers, particularly on an employer group purchase basis, where employees may live in very different geographical areas around the Commonwealth, there are hospitals that either because of geography or because of brand or because of specialty, clients, that means employers, and members, want in their network. Now, tiered networks are another way of approaching that, so that there is a greater opportunity to have a variety of providers in the network and as tiering becomes more significant, it's up to the consumer, up to the member or patient, to choose whether it is worthwhile to them to pay an additional co-pay in order to -- or deductible, in order to take advantage of providers that have a particular brand or other attractiveness.

Michael Bailit

Thank you. I've got one question I want to ask here, and I want to lead to spending our last ten minutes in terms of talking about potential strategies or solutions. Ellen, you've offered one already, but the special commission on provider price reform is just undertaking its efforts this summer, and so you can help inform that work. My first question comes from the audience and Andrei, I'll direct this to you. Do you support short-term intervention in the provider market to eliminate payment disparities? The Attorney General's office has suggested that there might be a temporary freeze of some or all, I can't remember which, pay rates. Would you support that or some other government intervention to address disparities?

Andrei Soran

Two points. Fundamentally, I believe in the market, so I believe at some point in time, the market forces should take precedent over everything else. However, and I think Ellen mentioned this in her remarks, to simplify, if we freeze the prices, we bake in the disparities. In order to change that, there has to be an intervention. I don't know if any provider that will voluntarily negotiate down their prices.

Michael Bailit

So what should be that intervention?

Karen Tseng

Sorry Michael, let me just clarify, so that we're debating the accurate recommendation, which is temporary restrictions and the extent to which prices for comparable services can vary. So there is no recommendation to freeze disparities in place; rather, the goal is to reduce variation where it's not explained by value.

Michael Bailit

Thank you.

Andrei Soran

And that's an appropriate recommendation, so I think that answers your question.

Michael Bailit

So you would endorse that? I'm trying to get at, what recommendations would you make, particularly given that you just said that you would endorse a market based solution. What's the market based solution to the problem with variation that we've been discussing?

Andrei Soran

I think that after an intervention, a temporary intervention, to then allow the market, within a certain bandwidth, that takes in account quality, complexity, and to some extent the integration of services, the ability to provide integrated care. Those should be the variances, but the variances should not be to the magnitude that we are experiencing now.

Michael Bailit

What you're suggesting then, at least I think and tell me if I'm wrong, that the intervention is actually an ongoing one and that government should define the allowable factors for variation, and that variation should exist for only those factors? Is that what I'm hearing?

Andrei Soran

I think that the market got out of hand and this intervention will bring it back to a reasonable level. I don't think we'll see a repeat of what happened, that created that wide range of disparity. So I think that's more a pointed temporary intervention. I don't think that -- at least my opinion is that there is not going to be a need for perpetual supervision.

Michael Bailit

Right. You think a short-term, temporary intervention will jumpstart us in the right direction. Norm, what do you think, what should we do?

Normand Deschene

I'm speaking on behalf of Lowell General Hospital and not the Hospital Association. I think there is some intervention necessary, especially around physician networks, who are growing around the state and exporting rates. And so to the degree that a physician today in Lowell is getting paid $100, signs an agreement with a network tonight and then tomorrow is getting paid $150 for doing the same work, I think that exportation of those rates needs to be addressed, because it's driving the cost of health care up.

Michael Bailit

Yeah, but I'm interested in how.

Normand Deschene

Well, I think some sort of governmental intervention needs to place in that regard. And I think the market -- I agree with Andrei, that there is going to be some market adjustment. However, I'm also in agreement with Ellen, that I think we need to look at organizing peer hospitals and addressing disparity amongst those peer hospitals, and we can't adjust for the factors that account for differences in rates within some bandwidth and adjust those accordingly.

Michael Bailit

All right. So you like -- because Andrei was supporting a temporary action and Ellen was supporting something that --

Normand Deschene

Right, I understood that. My support is temporary, because I think there needs to be a recalibration if you will, of the marketplace. And then, once people are closer, on the same level playing field, then I think the market can deal with those differences.

Michael Bailit

What would prevent the market from returning to where it was? I'm just curious.

Normand Deschene

Well I think there is a change, a fundamental change. I don't think enough attention has been given to some of the things that are going on in the marketplace over the last two years. We're looking at 2009, but I think the rate of cost growth has slowed down in 2010 and 2011. Again, in the Lowell market, we're seeing huge effects of our AQC contract, in that we're able to redistribute and relocate those patients who otherwise, out migrated for their care, back to Lowell. As I said earlier, in the course of three years, we've seen an 8 percent growth in our market share, and from our analysis, at least 7 percent of that is from patients who --

Michael Bailit

But is that addressing price variation?

Normand Deschene

Well, it's not addressing price variation but it certainly is adjusting the marketplace. I think with that growth, we will -- I think we're enjoying to some degree, a growth in our leverage. As more and more people choose us, I think our ability to negotiate better rates is enhanced. And again, those rates are going to be at a lower level than some of the more expensive academic centers.

Michael Bailit

Gary, I'm not sure we ever confirmed whether you thought that price variation was a problem for the Commonwealth or not, so I don't want to ask you for a solution to a problem that you don't think exists. So let me ask you first, whether you think price variation as not -- this doesn't have anything to do with how other people negotiate and how you negotiate, but looking at the chart that shows variation, is it a problem and if so, what solutions --

Gary Gottlieb

Well, I think the greatest piece of the problem is the underpayment of a set of providers, because as they're describing, their ability to both capitalize what's necessary for safety and quality, as well as to deliver services in a way that's effective and efficient, is hampered by what appear to be rates that are inadequate. And given that I am not uncomfortable essentially, with the ways in which we have been negotiating our rates, I believe that there is underpayment there and that disparity is a marketplace problem.

Michael Bailit

So the solution would be we should begin to pay the lower paid providers more?

Gary Gottlieb

Well, I think that one, there are already market factors. I think the Attorney General's report, in terms of movement, in terms of payment structures, really does require more time to appreciate the changes with shared risk, that AQC and other related products will likely bring to providers. If you look at Jim's trend over the course of the last three years, your overall medical expense trend has gone way down. I think to Andrei's point, and I would disagree somewhat, I think that all providers are going to have to be price sensitive, so that if there are groups of providers who are at risk and therefore are price sensitive and aware of those prices, that will create downward pressure on the highest priced providers in terms of the prices that essentially will be able to charge. And additionally, so that the providers themselves will create that sensitivity and additionally, tiered and limited networks again, will create a downward pressure on their price. That is a market intervention that essentially allows prices to move down substantially. Hopefully, they won't move down catastrophically, in a way that prevents providers that are doing lots of stuff that everybody would like to be doing, that the community needs, including behavioral health services, having burn centers, being able to essentially support community health and a variety of other critical factors in science, essentially are still preserved.

Michael Bailit

So you believe that -- an I'm just trying to say back to you what I think I'm hearing -- the marketplace is going to show new rigor, in terms of being able to put pressure on cost, which will hence, put pressure on price.

Gary Gottlieb

I believe that the market is absolutely already putting pressure on price, and I think that that will essentially put pressure on providers who are more expensive, to focus on trying to reduce cost per unit of service, as well as to come up with payment mechanisms that appreciate and create the ability to manage the highest risk and most expensive patients, where so much of the cost shifting exists in all the insurance products, as well as in the provision of service.

Michael Bailit

So if I try to summarize what I've heard from all of you, I'm hearing a range from Ellen's idea of creating a common price level and then allowing for negotiation, presumably above and below that, and within some limits Ellen or without limits?

Ellen Zane

Well my sense is that we really do need to keep most of the system private, and that should be a discussion in private between the provider and the health plan. So I think with the transparency of having a common platform, the transparency in and of itself will keep the limits where they need to be.

Michael Bailit

Okay, so I'm hearing that from you. I'm hearing, I think from Andrei and Jim and I think Norm, that you guys like the idea of a temporary action. Is that right Jim, were you thinking that as well?

James Roosevelt Jr.

Yes, that's right. A temporary action is something that should be considered and it should focus on outliers.

Michael Bailit

And then after the action is removed, there seems to be this belief that temporary action will sort of jolt us into a new place.

James Roosevelt Jr.

Well, I think that we should be given the opportunity and maybe even the requirement, to renegotiate affordable and reasonable risk based contracts. If those negotiations do not product affordable and reasonable contracts, then we should re-approach this question.

Michael Bailit

And who defines affordable?

James Roosevelt Jr.

I think that in the first place, the market should operate, but I think that as we have -- as we are doing with the commission that's just starting to meet and as we're doing annually in these hearings, there will be a public review of that.

Michael Bailit

And then last Gary, what I'm hearing from you is you think there needs to be a focus on increasing the rates for those who are lowest paid, and then you believe that the existing market pressures are going to put on the brakes.

Gary Gottlieb

I think the intensification of the market pressures that have begun, so I think that there is momentum really, that really intensified at the time of the greatest economic slowdown, when the disparity in growth of health care costs relative to essentially other value in the marketplace, really showed how dramatically health care costs are crowding out other critical services.

Michael Bailit

Well panelists, I'd like to thank you all, it's noon. Thank you for being open and sharing your responses with me, and thank you audience as well.

Seena Perumal Carrington

I want to further thank you for the panelists and the moderator. Michael, thank you again, I appreciate your time and commitment to providing high value care and addressing the challenges within the health care delivery system. This wasn't an easy conversation, but know there's a larger discussion on how to contain health care costs. We're going to break now for lunch and reconvene promptly at 12:45. Thank you.

[END OF PART 2]